



**Authorization for a one time release of personal health information**

Requesting the records of the following Plan Participant:

Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Previous Last Name (if applicable): \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ (mm/dd/yyyy) Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Caremark Plan Participant's Primary Cardholder Identification Number(s): \_\_\_\_\_

Name of Requestor (if different than above): \_\_\_\_\_

Relationship to Plan Participant:

- ☐ Self  
☐ Parent  
☐ Legal guardian (Attach legal documentation)  
☐ Other: \_\_\_\_\_  
(Attach legal documentation )

I hereby authorize Caremark to release the following information for the above-named Plan Participant:

- ☐ Statement of Cost from \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy)  
☐ Prescription History from \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy)  
☐ Other health information, please specify: \_\_\_\_\_  
\_\_\_\_\_ from \_\_\_\_\_ (mm/dd/yyyy) to \_\_\_\_\_ (mm/dd/yyyy)

This information should be released to: ☐ Check if same as address above.

Name: \_\_\_\_\_  
Organization/Entity: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_

The purpose of this authorization request is:

- ☐ At request of plan participant  
☐ Required or requested by the recipient for purposes of \_\_\_\_\_  
☐ Other: \_\_\_\_\_

This Authorization will expire 90 days from the date of this authorization.

I understand that I have the right to revoke this Authorization at any time. This revocation will not affect any uses and/or disclosures already made based on this authorization before the revocation is received by Caremark. The revocation must be in writing and mailed to the address below. I understand that Caremark may not condition any treatment, payment, enrollment or my eligibility for benefits on my signing this Authorization. I understand that the information used and/or disclosed pursuant to this authorization may be redisclosed by the recipient and may no longer be protected by the federal privacy law.

I certify that the foregoing information is true and correct.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Print Name: \_\_\_\_\_

If signed by someone other than the above-named plan participant, please describe your legal authority to act on behalf of the participant and, if applicable, attach supporting documentation: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Witness Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please Return Form To:  
Caremark  
P.O. Box 659529  
San Antonio, TX 78265-9529